

SATURDAY, OCTOBER 12, 1872.

ORIGINAL LECTURES.

CLINICAL LECTURE

ON CONGESTION OF THE SPINE.

BY DR. H. C. WOOD, JR.,

Physician to the Philadelphia Hospital; Clinical Lecturer on Diseases of the Nervous System to the University of Pennsylvania.

GENTLEMEN: The case which I bring before you to-day entered the wards of the hospital on the 20th of May, 1872. She had been drinking very heavily for some months, and was admitted to the "drunk-wards." The evening she came in she could walk very well. The night of the 21st, she had decided hallucinations, with sleeplessness, but these readily yielded to appropriate treatment. On the morning of the 22d the resident physician, Dr. Levy, first noticed the existence of paralysis, which he says deepened until the 24th, when it became stationary. She herself declares that she began to lose power over herself on the 21st, and by the 22d or 23d was completely paralyzed. When I first saw her, on the 26th, she lay in bed, calm, collected, with no psychical or constitutional disturbance whatever. There was no difficulty of respiration. The muscles of the face and neck were normal. The arms were completely paralyzed, but she could move the fingers of the left hand; in the right nothing stirred at her will. The right leg was completely paralyzed, but when lying in bed she could raise the left leg clear. There was some anæsthesia of both legs, but especially of the right, as tested by the compass-points. She complained of no decided pain, only heaviness and numbness in the limbs, and a feeling as if they were asleep. There was little or no back-ache, no sensation of a tightened cord around the waist. There had been no spasms whatever, except in the left leg, in which occurred occasional jerking movements, especially when excited by touching, tickling, or electrical excitement. The urine could be retained for short periods of time, but her bladder had to be frequently evacuated, or else she had involuntary discharges. The bowels were very costive. Reflex movements were very much lessened, except in the left leg, where they seemed to be heightened. The muscles were everywhere soft and relaxed. The pupils were natural.

About a week after her seizure, an electrical examination of her muscles gave the following results:

In the left leg, with primary currents (currents of the first coil of Duchenne), the response of the muscles was feeble, unless a strong current was used, and then the action was not so strong in the right as in the left leg. Through some strange omission, nothing is said in the notes as to the condition of the muscles of the arms at that time; but on the 17th of June it was noted that the muscles of the right upper arm failed to respond to the strongest induced current (probably primary current).

When this case presented itself, the first thing

was to decide the nature of the attack. A very brief review of the history convinced me that the lesion was spinal, not cephalic, or, in other words, that the cause of the paralysis was in the spinal cord and not in the brain. The fact that determined this decision was the absence of any symptoms of brain palsy, such as disturbance of special sense or psychical functions. It was also apparent that there was no serious trouble in the spine above the origin of the fourth cervical nerve, as respiration was not seriously disturbed, and the function of the phrenic nerve, whose chief roots are the third and fourth cervical nerve, was not interfered with.

Moreover, it was equally plain that there was not any deep disorganization of the cord, for, whilst the motor functions of the brachial plexus—that is, the motor functions of the spinal nerves from the fifth cervical to the first dorsal—were almost abolished, the pupils were in no way abnormal. The vaso-motor nerves which supply the pupil have their origin in the region just spoken of, and the complete performance of their function was evidence not only that they were intact, but also that there was no disorganization of the cord.

The points in the case to be prominently borne in mind in making the diagnosis were:

1. Suddenness of onset.
2. Universality of motor paralysis.
3. Partial sensory paralysis.
4. Absence of all symptoms of irritation of the cord, such as spasms, or shooting pains in the limbs.
5. Absence of disorganization of the cord.
6. Absence of constitutional symptoms.

A glance at these, the main points of the case, showed that the disease could not be either acute meningitis or acute myelitis. Both of these affections are marked by intense suffering, fierce shooting pains, cinctures of intolerable anguish; in both there are also symptoms of motor excitement, such as spasms of the muscles of the arms and limbs, opisthotonos, general tetanic phenomena; and they also have, in common, fever and other symptoms of grave constitutional disturbance.

These affections having been laid aside, the next question which presented itself was, Has the patient hysteria? I decided not, and for these reasons: There were no other symptoms of that hydra-headed disease—no drooping eyelid, no craving for sympathy, none of the slight indications which betray the psychical disorder. Further, I have never seen hysterical paralysis so universal. Paraplegia from such sources is not very uncommon, but general persistent paralysis I have never witnessed. Again, in hysterical paralysis, according to Moritz Meyer, the electro-muscular sensibility is soon partially or completely lost; but our patient complained with sufficient bitterness when the galvanic current was applied to her limbs.

Another explanation of the case that offered itself was, that there had been hemorrhage into the cord,—an apoplexy of the cord brought about by the abuse of alcohol. This supposition was also rejected, not because such accident is almost infinitely rare, but because it seemed impossible that a hemorrhage

sufficient to have caused such grave disturbance should not be followed in a few days by unmistakable evidences of spinal disorganization.

By this reasoning we laid aside, one by one, all the acute diseases of the spinal cord, except that known as *congestion*.

Now let us consider in detail the phenomena of this affection, and see how far they agree with those offered by our case.

The cause of the disease, according to authors, is diverse. Ollivier assigns suppression of the menses or other discharges, as a frequent cause, and in this has been followed by most subsequent authorities. Hammond states that he has seen several cases apparently due to long standing; Radcliffe and others speak of venereal excesses; but all authorities appear to agree that one of the most common causes is exposure to cold, especially lying upon the back on the cold ground. It was just such an exposure which produced the attack in our patient. In her drunken unconsciousness, she lay upon the ground and in the wet, reckless of consequences.

The onset of this disease is very generally sudden. Rarely it may happen that the paralysis develops only in the course of one or even more days, but in the majority of instances it comes on with great rapidity and abruptness. Thus, Ollivier details the case of a lady who, when her menses were due,—their coming had been announced by the usual symptoms,—took a cold bath in the morning, and whilst dining out the same afternoon suddenly felt paralyzed; and Hammond tells of a lawyer whose long, labored speech was brought to an abrupt close by a similar incident.

In the present case, there had been, according to the statement of the patient, indications of spinal trouble for some two or three weeks. She says she had for a long time drank on an average over a pint of the commonest whisky daily, and it seems impossible to decide how far the weakness and stiffness in the legs, the intense itching of the skin, the pricking and numbness of the fingers, were really due to threatening spinal congestion, and how far to the exhaustion of prolonged over-stimulation of the nervous centres. Be this as it may, she could walk well enough when she entered the hospital, on the evening of May 20. On the night of the 21st she had marked hallucinations, with sleeplessness, which readily yielded to appropriate treatment. On the 22d, the attention of the resident physician, Dr. Levy, was first called to the existence of the paralysis, which he states was not so complete at that time as when I first saw her—on the 24th. She herself states that the paralysis developed almost entirely during the day and night of the 21st.

It is evident then that, in the case under consideration, the attack, though exceedingly rapid, was not so absolutely sudden as in some cases.

In the fully developed affection a primary fact is the total absence of fever or other general constitutional disorder. The symptoms are purely local in their character. The paralysis is distinguished by its being very general, but often incomplete, as well as, according to Radcliffe, by its coming irregularly, creeping, as it were, from limb to limb. The blad-

der and rectum very often are not affected, but, although some authorities assert to the contrary, they certainly are in some cases involved. In the case before you, the patient was able to retain her urine for a time, but if she had not opportunity to empty her bladder frequently, she had involuntary discharges from it.

The disturbances of sensation are less marked than those of motion. Radcliffe asserts that there is no anæsthesia or numbness, but Hammond is certainly right in stating that, although there may be hyperæsthesia in some cases, yet anæsthesia is not rarely present. There was certainly in our case a very decided but far from total loss of sensibility, with a pronounced feeling of numbness.

Reflex movements are never intensified, and, in most cases, but slightly affected, but in the present instance were very much diminished; the spinal cord seemed to have almost lost its power of answering peripheral irritations.

Pain is never a very prominent symptom. Sometimes the patient complains of a dull aching in the back, increased by a recumbent posture, or by the application of warmth. It was somewhat remarkable that in the present case this aching was not complained of until a marked improvement had occurred in the symptoms.

When pains in the limbs do occur, they are to be distinguished from those of myelitis and meningitis by being less severe, and by not being aggravated by motion. Tingling, formication, and the minor symptoms of æsthesiodic disturbance, are very common.

In our case no record was kept of the temperature of the limbs, but according to Hammond it is generally lowered, owing to vaso-motor paralysis.

The disorders of nutrition are not nearly so marked as in acute myelitis. Bed-sores I have never seen, but they are asserted to form in some cases. The electro-muscular contractility, although in severe cases diminished, is often only slightly so, and is very rarely totally lost in any muscle or group of muscles. When it is so, I think we are justified in asserting that there has been in such cases an effusion, which has produced serious organic changes in the portions of the spine which supply the affected muscles.

Quite recently Dr. Mitchell has noticed that the growth of the nails is arrested in hemiplegia, and I consequently stained the nails of this patient early in her attack. There certainly was a *partial* arrest of growth in the nails, especially in the right hand, which was much more deeply paralyzed than the left. Up to the 10th of June, the nails of this hand had scarcely grown at all; then, however, they began to grow with more rapidity, but still much more slowly than those of the other hand.

The course of the case is ordinarily favorable; after a more or less lengthened period of time, the symptoms usually yield to appropriate treatment, and recovery takes place. Sometimes, however, the paralysis deepens and the case ends fatally; generally this happens, if at all, within a few days or weeks from the beginning of the attack.

The mode of death is by asphyxia from paralysis of the respiratory muscles.

There can be no doubt that the affection which we have been considering is a distinct one, separate from its allied diseases. Death from it is comparatively rare, and but few autopsies have been reported. In those which have been recorded, there have been no marked changes discovered in the cord itself, but the vessels outside of the cord have been found in a high state of engorgement, and in some instances there has been apparently a very decided serous effusion. In a case reported by Ollivier, it is expressly stated that it was chiefly the plexus of veins lying between the vertebral column and the dura mater which were affected.

The symptoms are evidently simply the result of pressure on the cord. Ollivier accounts for the fact that the motor elements are much more disturbed than the sensory, by anatomical reasons. He says the anterior portion of the cord is always kept close to the posterior face of the vertebræ by the spinal roots, whilst the posterior portion is five or six lines from the corresponding face of the canal. The result of this is that liquid interposed between the cord and canal exerts much more pressure upon the anterior than the posterior part of the cord. At the same time, there is also a congestion of the vessels of the pia mater, and this effort of dilatation acts almost exclusively upon the anterior face of the cord, on account of its being so close to the resistant vertebræ. Hence the anterior columns especially suffer compression.

I think that there is some force in these facts, but we now know that the sensory impressions are chiefly transmitted through the gray matter, which, being situated near the centre of the cord, must be the last portion of it to feel the effect of external pressure.

ORIGINAL COMMUNICATIONS.

CYSTIC ENCEPHALOID OF THE OVARY AND OMENTUM.

BY A. C. W. BEECHER, M.D.

MRS. A. E., æt. 26 years, married, has one child. She is small in stature, and delicately built; her health has been delicate from her childhood.

February 6, 1871, I was called to see her, and found her suffering from sharp pain in the right hypochondriac region, which prevented sleep, and destroyed her appetite. She informed me that about two weeks before, having some snow on the soles of her shoes, she slipped upon an oil-cloth in the house, and received a severe fall, bruising her face, and producing ecchymosis about the right eye, and on the right side of the chest and abdomen. The fall was followed by unconsciousness for a short time. For the two weeks succeeding this accident, she coughed up blood, varying in quantity and attended with considerable pain.

The urine was dark-colored and turbid; there was difficulty in micturition and in defecation. Most of these symptoms had subsided when I first

saw her. Suffering had left its impress upon her countenance. Hypodermic injections of morphia, with hydrate of chloral internally, produced only temporary relief from pain. Tonics and nutritious diet were directed for support. A frequent sensation of nausea was guarded against by lime-water. She continued in some comfort for several weeks, but confined to the house. The pain in the right side continued, and was aggravated by pressure. Hepatic dulness seemed about normal. The abdomen then began to enlarge as in ascites, not rapidly, but gradually, and palpation showed the existence of fluid, which did not materially lessen in quantity under the use of diuretics. The return of pleasant weather enabled her to take some out-of-door exercise. She also left the city for a short time, but an aggravation of symptoms induced an early return. I found the abdomen increasing in size, the pain continuing, and the constipation only relieved by cathartics. The superficial abdominal veins were very much enlarged.

September 11, Dr. J. M. Da Costa saw her, and diagnosticated a solid tumor of no small dimensions in her abdomen, in addition to the fluid. It seemed to extend from the margins of the ribs to the umbilicus, and, as it was not connected with the liver, there being diminished hepatic dulness and no splenic enlargement, its character was decided to be peritoneal growths with ascites from pressure, or ovarian tumor. A subsequent digital examination per vaginam failed to show any uterine or ovarian involvement, there being the usual free motion of the organs. Her abdomen at this time measured $39\frac{1}{2}$ inches in its largest circumference. She was much emaciated from pain, loss of sleep, loss of appetite, and the great weight. As she had been nursing, there had been no catamenial discharge. Hydrarg. chlor. corros. gr. $\frac{1}{4}$, and infusion of scoparius, had been given for some time, as suggested by Dr. Da Costa, but with little benefit. She continued growing worse, particularly as to the abdominal enlargement.

December 11.—Dr. Da Costa again saw her. Emaciation had increased very markedly; greater tenderness on pressure of abdomen, which now measures $43\frac{3}{4}$ inches. She has much shortness of breath, caused by the pressure upwards of the tumor and fluid. Cannot lie down to sleep, from a sense of suffocation. The tumor is now regarded as malignant. From this time she grew worse rapidly, all the symptoms being aggravated. Anodynes had no effect, except in large doses.

January 16, 1872.—She died from exhaustion, having shown remarkable tenacity of life.

Post-mortem examination, made twenty-four hours after death.—Countenance bore expression of long suffering; body exceedingly emaciated; superficial abdominal veins very much enlarged, and the skin and subcutaneous tissue over the line of their courses deeply ecchymosed; abdomen measured 45 inches in circumference. A longitudinal incision was made in the median line, extending from the ensiform cartilage to the pubic symphysis. Bloody serum, containing a pinkish, shred-like material, was removed to the amount of

three gallons. The tumor was adherent to the anterior abdominal walls over a surface 15 inches in diameter, and dissection was required to separate them. Posteriorly and laterally, the tumor was entirely free; superiorly, it was attached to the omentum, which was almost entirely involved in the growth; and inferiorly, to the left ovary, which was entirely lost in the tumor, no trace of ovarian tissue being detected upon careful subsequent dissection.

Though in one large envelope, the tumor was lobulated and cystic in character; the cysts did not extend entirely through it. The incision in the linea alba opened a cyst from which was taken a small quantity of bloody fluid, with a large quantity of shreds of broken-down tissue. The other cysts had similar contents. The tissue in the solid lobes was of a yellowish-white color, and not very firm; it resembled cerebral substance. The cyst-walls were thick and dense, varying from $\frac{1}{4}$ to $\frac{1}{2}$ inch. The veins running through the tumor were enormously distended, and capable of admitting the little finger.

The left Fallopian tube was stretched to seven inches in length, and its calibre wide enough to admit a large uterine sound. It lay close along the inferior portion of the tumor, and was not involved, being freely movable along its entire length. The tumor was 18 inches in its longest diameter, 15 inches in width, and nine inches in thickness, and by actual weighing was 25 pounds.

An examination of the specimen by Dr. Da Costa determined it to be cystic encephaloid of the ovary and omentum. The specimen is now in the Jefferson College Museum.

The liver was somewhat contracted and pale in color; the spleen was about normal in size and color. The kidneys were pale, but presented no marked degeneration. The other cavities of the body were not examined.

In making the examination I was assisted by Dr. William H. Webb, who also saw the patient with me several times during life.

TRANSLATIONS.

A FEW REMARKS UPON THE RELATION OF HÆMOPTYSIS TO PULMONARY CONSUMPTION.

Translated for the *Philadelphia Medical Times* from the German of Professor Felix von Niemeyer.

BY HAMILTON OSGOOD, M.D.

THREE years ago, through my assistant, Dr. Ott, I published, in the *Berliner Klinischen Wochenschrift*, a series of clinical lectures upon pulmonary tubercle and pulmonary consumption, beginning with the following words:

"No doctrine in the whole range of pathology demands a thorough reform so urgently as the doctrine of pulmonary consumption. In this direction, clinical medicine has become completely superseded by pathological anatomy. The expression 'tubercle of the lungs' is still the most frequently-used designation for consumption of the lungs; a proof that the majority of

physicians and clinical teachers of to-day hold fast to the stand-point of Laennec, and recognize only one form of consumption, viz.: tuberculous consumption. The dangerous assertions of Laennec, that '*pulmonary consumption is a constitutional disease, which can never develop itself from an acute or chronic pneumonia, never from a bronchial hemorrhage, never from a neglected catarrh*,' are even now repeated from the lecture-chairs as incontestable truths, and, in practice, exercise upon the prophylaxis and treatment of consumption the most prejudicial influence."

The thorough reform of the theory of pulmonary consumption, which three years ago I indicated as being so urgently necessary, was not long in coming. The views of physicians respecting the relation of pulmonary tubercle to pulmonary consumption have since that time undergone an almost entire change. To-day, the above-quoted opinion of Laennec, which three years ago was perfectly allowable, and the correctness of which was at that time denied by nobody, is no longer accepted. I may be permitted to maintain that my clinical lectures, which met with an uncommonly rapid and wide-spread reception, and which were soon followed by the excellent works of Hoffmann, Colberg, Waldenburg, and others, contributed essentially to this change, as well as to the clinical value of the works of Virchow and Buhl, which by practitioners have for years remained almost unnoticed.

But few passages of the mentioned publication have experienced serious attack. Indeed, even the assertion that "*the greatest danger of most consumptives is that they may become tuberculous*," which at first, from various sides, was designated as going too far, or as whimsical, after having received, through countless experiments upon animals, a weighty confirmation, is now almost universally recognized as perfectly correct. Only in respect to the relation of pulmonary and bronchial hemorrhage to consumption of the lungs is the correctness of my views disputed, and in this instance by a weighty authority,—Geheimrath Traube, of Berlin.

Traube, apparently, does not share the opinion that under certain circumstances the product of acute or chronic catarrhal pneumonia, and in some cases also the product of croupous pneumonia, undergoes a cheesy metamorphosis. He evidently still holds fast to the old theory, according to which one must, from the cheesy metamorphosis of the infiltrates, which have been the result of a certain kind of inflammatory process, infer the "tubercular nature" of the same.

Under the title "*A case of acute tubercular (cheesy) pneumonia with rapidly fatal termination*," Dr. Fräntzel published, in 1867, the following case, including observations by Traube:

A clerk, æt. 28, who claimed to have been previously healthy, experienced on the 24th of May a severe attack of chills. This attack was succeeded by constant fever and cough. Several days later, spitting of blood set in, which became so considerable as to lead the patient to seek admission to the Charité. Here it was found that the body-temperature was 40.1° R., the pulsations 100, the respirations 48. Examination of the chest discovered a marked and extensive condensation of the left lung, and abundant râles in the same, but no bronchial respiration. The spitting of blood continued, as did the fever; the respirations increased to 60 in the minute; the patient began to be delirious, and at length insensible. Collapse set in, and on the seventh day after his admission to the hospital, and thirteen days after the attack of chills, the patient died.

Autopsy.—Excepting several old, indurated nodules, and a few smooth-walled cavities of the size of cherry-stones which were found in the apices of both lungs, the autopsy revealed simply a very extensive lobular infiltration of the entire left lung. Within the firm,

grayish-red, granular, hepatized localities were, here and there, found nodules from the size of a pea to that of a bean, which were undergoing cheesy metamorphosis. In the right lung were also found small, scattered, clear grayish-red hepatized spots. *In no place did the bronchia contain either fresh or old blood-clots.*

That in this case the pneumonia was not the result of the hæmoptysis, but the hæmoptysis the consequence or a symptom of the pneumonic process, cannot be doubted; and I do not hesitate to admit that through this case of Traube's my attention has been called to a connection between hæmoptysis and the inflammatory process which leads to pulmonary consumption, which, in my clinical lectures, as well as in the seventh edition of my Pathology, I have neglected to mention. On the other hand, however, I am far from believing with Traube, in spite of his rich experience, and his gift of keen observation, that those cases in which hæmoptysis is a symptom of a pneumonic process are either abundant or form the rule. Still less do I accept his belief that the countless cases of phthisis which, according to the experience of every century, follow hæmoptysis, are always, or even generally, dependent upon the progress of that process which lays the foundation of the hemorrhage,—let one designate it tubercle or tubercular pneumonia, as he will.

In my earlier experience only *one* case fell under my notice which conforms to that of Traube's patient. The parallel is very striking. I speak of a young theological student from Switzerland. In his case, severe fever and other pneumonic symptoms appeared synchronously with the hæmoptysis, and accompanied the same to the fatal end, which occurred in the middle of the second week, it having been impossible to check the hemorrhage. In the last days of his sickness the patient fell into a furious delirium. The post-mortem discovered, in both lungs, pneumonic infiltrations, which when cut showed an indistinctly granular surface, without indications of cheesy change. *The bronchial tubes were perfectly free from coagula.*

Since Traube's case became known to me, I have noted with greater exactitude than formerly, in every case of hæmoptysis which I have had opportunity to observe, the presence or absence of fever and other pneumonic symptoms, and especially the time when the hæmoptysis took place. In only one case, however, has it appeared to me probable that the hemorrhage was a symptom of a pneumonic process. In every one of the remaining cases, the fever and inflammatory indications failed either during the entire course of the hemorrhage, or at least in the first days of the same. In the case of a young Swiss physician who was attacked by an hæmoptysis of rather severe character, the body-temperature while the patient remained in my charge did not exceed 37° R. He went home several days after cessation of the bleeding. There, without experiencing a return of the hemorrhage, he was seized with pleuritic pains; whether the pains were attended with fever, and what the later history of the invalid was, I have not learned.

The rare cases of pneumonia which are connected with a capillary hemorrhage of such abundance as to come under the head of hæmoptysis, appear, therefore, to be especially dangerous, because the infiltrations to which they lead possess an eminent inclination to cheesy metamorphosis. But we have no reason to refer the frequency of this issue to any peculiarity of the pneumonic process. The profuse admixture of blood in the inflammatory product is amply sufficient to show that the infiltrate is liquefied and absorbed only with difficulty, and that it frequently degenerates into cheesy metamorphosis. *Ceteris paribus*, a more unfavorable prognosis is made, and one may fear that the disease will not terminate in a breaking up of the de-

posits, when the sputa of a croupous pneumonia, instead of the yellow-brown tint, exhibit a color similar to that of plum-sauce. In a hemorrhagic infarctus it is precisely the rule that the originally dark-brown nodule, by a lengthened process, becomes yellow and cheesy.

With the exception of that rarely occurring hemorrhagic pneumonia (which heretofore I have omitted to mention) which leads to hæmoptysis, and later, through cheesy metamorphosis and the destruction of the infiltrates which have remained, to phthisis, I think I shall be able to refute with ease the objections which Traube has raised against my views touching the connection between hæmoptysis and pulmonary consumption.

The positive assertion of Laennec and Louis, viz., that even in those cases in which hæmoptysis precedes the cough, the sputa, and all other signs of pulmonary phthisis, tubercle had already a pre-existence in the lungs, has, it is true, until within a short time, been held by physicians as absolutely correct. This assertion, however, as I have long ago said, rests not by any means upon experience derived from the autopsies of fresh cases of hæmoptysis, but always upon the hypothetical argument that lung-consumption depends upon a new formation, and that this new formation cannot well proceed from blood which has flowed into the alveoli of the lungs.

The correct view is, that miliary tubercle, which, of course, very frequently pre-exists in phthisical lungs, develops itself, in the greater number of cases, only in an *advanced* stage of the disease, and that inflammatory processes in the lungs form the common point of origin for phthisis. By the side of this belief, it is self-evident that the theory against the dependence of lung-phthisis upon pulmonary hemorrhage falls to the ground. Possessing the correct view, one is no longer obliged to assume that all those individuals who, becoming attacked by hæmoptysis in the midst of apparently perfect health, immediately thereupon show the first signs of consumption of the lungs, have, before the appearance of the hemorrhage, been mistaken in regard to the condition of their health. It became pressingly necessary to submit to a new proof the doctrine which the most prominent inquirers, from Hippocrates to Laennec, omitted from their observations,—namely, that many cases of phthisis develop themselves from an hæmoptysis.

I have therefore for years followed, with the greatest possible exactitude and freedom from prejudice, every case of pulmonary hemorrhage which has fallen under my observation. In every instance, I have taken especial pains to ascertain the physical condition of the patient, both before the hemorrhage and at the beginning of the same. The experience of every physician in active practice will certainly agree with mine, viz., that those persons who have repeatedly suffered from epistaxis are later preferably disposed to attacks of spitting of blood, and that, customarily, the earlier attacks of epistaxis, as well as the later seizures of hemorrhage of the lungs, are in no way accompanied by constitutional disturbances, fever, or inflammatory indications, but on the contrary, while experiencing surprise and fright, the patients in other respects feel perfectly well. This experience led me to affirm (in a dissertation written under my supervision by Dr. Bürger*) that the morbid erosibility of the capillaries (hemorrhagic diathesis), which is especially observed in poorly-nourished, weak, delicate individuals, after a rapid growth, or other exhausting influences, leads, during childhood, to capillary hemorrhage from the mucous membrane of the nose; at puberty and soon after, preferably to capillary hemorrhage from the bronchial mucous membrane.

[Conclusion in our next number.]

* Ueber das Verhältniss der Bronchial- und Lungenblütungen zur Lungen-schwindsucht.

NOTES OF HOSPITAL PRACTICE.

JEFFERSON MEDICAL COLLEGE.

SURGICAL CLINIC OF PROF. S. D. GROSS.

Reported by FRANK WOODBURY.

A CASE OF SARCOMA OF THE ILIUM.

WILLIAM P. JOHNSTON, nineteen years of age, first appeared at the surgical clinic on the 19th of last June, during the service of Dr. S. W. Gross. He was kindly sent to the clinic by Dr. Roland, of Media, who had been attending him, and regarded it as an interesting case. At that time he seemed as if he were laboring under a wasting disease, or as if his nutrition was greatly impaired. His face, which was pallid and anæmic, wore a despondent look, the result apparently of physical or mental suffering. He was thin and emaciated, and said that he was losing flesh. The affected limb was partially drawn up, the knee and thigh being semi-flexed; the knee was close to its fellow, and the foot was directed outward as in an ilio-pubic dislocation of the femur. It was also thinner than its sound neighbor, from a partial atrophy of its muscles.

He gave the following history: About one year before his appearance at the clinic, while working in a lumber-yard, a heavy plank fell upon him, striking him forcibly on the right hip at a time when he was bending forward to lift something from the ground. The injury was followed by loss of consciousness, and he was confined to his house for a week from its effects. Two weeks subsequent to this accident, an abscess formed at the spot, and discharged a large amount of unhealthy, dark-colored pus, of an offensive odor. He had apparently entirely recovered, when he caught a severe cold from exposure to a storm. This brought back the pain, which he considered at the time to be of a rheumatic nature. This was two months after the accident. This pain continued, being almost constant, but not severe, for about eight months, at the end of which time he began to find an increased difficulty in walking, and, on examining, first noticed a hard swelling of large size at the situation of the present tumor, which he thinks has increased but little since that time, but which has so disabled the limb as to oblige him to use a cane in walking.

The tumor projected posteriorly, apparently from the sacro-iliac symphysis to the anterior superior spinous process of the iliac bone, and from its crest almost to the tuberosity of the ischium. There was a corresponding tumor in front, protruding the anterior wall of the abdomen as far over as the umbilicus. The tumor was of large size, firm, immovable, elastic, with an apparent sense of fluctuation at one point. The skin was natural in appearance, was not adherent to the mass, and there were no enlarged subcutaneous veins. There was preternatural heat in the part, which was evidently several degrees warmer than the opposite side of the body. The tumor was smooth, not tuberculated or nodulated, and gave but little pain, which was more of a dull and aching than of a sharp or darting character. The following measurements were taken over the tumor, and contrasted with those on the opposite side:

	Over the tumor. On opposite side.	
Diagonally, from the posterior superior spine of the ilium to the great trochanter . . .	11 inches.	7 inches.
Transversely, from the spinal process of the sacral vertebra to anterior superior spinous process . . .	11½ "	11 "
Vertically, over the most prominent portion of the tumor from		

about the centre of the crest to the tuberosity of the ischium	13½ inches.	11 inches.
Around the body, from the sacral vertebrae to the median line in front . . .	18½ "	16 "

His appetite was good, the digestive functions were well performed, he had no headache and slept well.

September 7.—He appeared again at the clinic. The tumor had evidently increased in size, but did not exhibit any tendency to ulceration. His general health remained good, although he was still losing flesh.

Prof. Gross examined the patient. The tumor, which was quite solid throughout, extended nearly to the ischial tuberosity, and was the seat of a constant aching pain. A number of enlarged glands were found in the groin above Poupart's ligament.

The lecturer said, "The original injury may or may not have influenced the production of the disease. The affection might have presented itself in the part if the accident had never occurred. Patients often ascribe a supposed origin to diseases with which they could not have the slightest connection. Too much reliance must not be placed on the statements of patients, as they may mislead, even when not made with that intention; although the contrary is frequently the case, especially in diseases of a venereal origin.

"What is the nature of this tumor? The skin above it is natural and not adherent, the subcutaneous veins are slightly enlarged, but not so much so as they generally are in the variety of carcinoma known as encephaloid, which obtains its name from the resemblance it bears, on section, to the human brain, and is for the most part soft and elastic in consistence. This tumor is dense and firm; it is, therefore, not encephaloid. It is not scirrhus, because I have never seen scirrhus attain such a bulk; it is generally small, and occurs most frequently in the mammary gland and uterus, and in the liver, anus, and rectum; rarely, if ever, occurring in the bones, tendons, ligaments, muscles, brain, lungs and spleen, or in the vessels and nerves. This is not a colloid tumor; for, although colloid tumors attain a large size in the peritoneum and ovary, yet they rarely occur on the surface of the body; and, even in such a case, there could exist no danger of confounding this dense, hard tumor with colloid, which is, as its name implies, of a jelly-like consistence. This is not a fatty, hydatid or fibroid tumor, nor is it epithelioma. It is none of these; it is sarcoma. But this name conveys a wrong idea of the pathology of the disease. It means a fleshy tumor, whereas it is not more fleshy than a number of other tumors to which the name might with equal propriety be applied. It is an old name which was revived by Virchow, and by him used to designate a class of tumors which are not essentially malignant, and which, until within a few years, were confounded with encephaloid disease. Sarcoma exists in a variety of forms, which have been divided according to their microscopical characters into round-, spindle-, and giant-celled, the form most commonly met with being the round-celled variety, which exhibits itself in different portions of the body. In this case I notice an enlargement of the inguinal glands, which is unusual, and which I consider a grave symptom. The glands generally become enlarged in the neighborhood of an encephaloid tumor in a state of ulceration; and accompanying scirrhus there is an enlargement and induration of the surrounding glands, which is supposed to be due to direct absorption of the cancer-elements. This, however, is rare in sarcoma. From the appearance of this tumor I should consider it as belonging to the round-celled variety. It is quite as unrelenting as cancer, and the only efficient remedy is prompt and early removal. If in the present case this disease were in its incipency or earlier stage, I should not doubt the pro-

priety of such an operation, nor hesitate to perform it. But now this is out of the question; the condition of the patient, the ganglionic involvement, the extent of the operation,—which would involve laying open the abdominal cavity,—all forbid such interference; it would only hasten the fatal issue. Even were the operation successful, the disease would return in a few weeks either in the cicatrix or in some vital organ. We can do nothing for the patient except to try to sustain his general health; if he suffers pain, we will give him an anodyne. Pain is a direct evil, and oftentimes claims treatment, especially in cases where it interferes with health by preventing sleep or producing mental distress. You must not let your patients suffer.

"The prognosis in this case is very clear and unmistakable. We will give him no medicine, as it would be without effect except to disorder his stomach. He may take some gentle exercise every day in the open air, and get as much food and sleep as possible.

"I had a case in my private practice somewhat similar to this, during the latter part of last term. The patient was a young married man, twenty-eight years of age, who had a tumor in the calf of the leg, which I pronounced sarcomatous and carefully removed. This shortly returned, and was followed by a second operation, but when it recurred again, which it did soon after, I advised amputation. This his friends would not consent to, and, being overruled, I again cut it out, but was not successful in obtaining all the morbid structure, as it extended into the popliteal space. This was followed by another recurrence of the disease, and this time I performed Teale's amputation at the junction of the middle and lower third of the thigh. The operation was followed by extensive suppuration, but the stump finally healed. The man died a few months later, with symptoms of solidification of the left lung. I was unable to obtain a post-mortem, as the patient was a Hebrew, whose religion forbade such an examination; but I am quite certain that he died of sarcomatous disease of the lung. Notice the history. The patient had sarcoma of the leg, which repeatedly returned after apparent extirpation, showing a special tendency to the disease existing in his system. After its usual seat of manifestation was removed, it suddenly invaded one of the internal organs, and the man died—not from pneumonia, but—from a sarcomatous deposit in the lung. There was not in the last instance, strictly speaking, a return of the disease, but there was a fresh development of it in another part of the body.

"If you have the opportunity of extirpating a tumor of this kind in its earlier stage, always do so, but do not be too sanguine. There is always danger of return in some internal organ, and the chances are that the patient will ultimately perish from the disease."

MAMMARY ABSCESS.

A young married woman, 27 years old, applies for treatment for a painful swelling in the right mammary gland. She has been confined eight weeks before. The breast is swollen, tender, and painful to the touch; and the skin over the affected part is tense, hot, and discolored, and has a peculiar glazed appearance. The tumor is not diffused, but is limited to one portion of the breast, and on touching it there is a sense of fluctuation as if its contents were fluid. This is readily distinguished from the false fluctuation in anasarca and oedema.

This affection is a phlegmonous abscess of the mammary gland, commonly called, by the women, a gathered breast. I have divided abscesses into two kinds: the phlegmonous, which is acute in character, is accompanied by a high degree of inflammatory action, runs its course quickly, is exquisitely sensitive, and is accompanied by throbbing pain; and the scrofulous or

strumous, known as the cold abscess from the absence of inflammatory symptoms, or chronic, on account of the slowness of its development. The latter is only met with in persons of a peculiar diathesis, who are particularly liable to phthisis and other tubercular diseases; the former occurring much more frequently, and being seen in all ages and conditions of life.

This trouble was preceded by inflammation of the gland, or mastitis, which frequently occurs during lactation, and may be due to a number of causes, the most prominent one being suppression of the cutaneous perspiration. It generally makes its appearance within the first fortnight following parturition, and exhibits itself in the shape of small lumps, which are rather hard and deep-seated, quite tender to the touch, and about the size and shape of an almond. These are inflamed lobules, and from them the inflammation may quickly extend to surrounding lobules and may gradually involve the entire gland, which becomes swollen and heavy, and the skin over it is hot, discolored, and glossy, perhaps a little oedematous. The secretion of milk is interfered with, as the galactophorous ducts are choked with the accumulated secretion. This condition if not timeously arrested passes quickly into suppuration, forming a mammary abscess. The inflammation in its early stage may be checked by mild stimulating applications, such as linimentum ammoniac, or warm oil with laudanum. These are to be frequently used; the nurse, in applying them, standing behind the patient, and gently rubbing the lotion on the affected gland with her hand, the direction of the friction being toward the nipple. This generally softens the induration in a short time, and promotes the flow of the milk. Combined with this, the patient may be treated on general antiphlogistic principles; occurring in a plethoric person, it may be necessary to take a few ounces of blood, either from the arm, or by leeches, from the affected part. The diet must be of the lightest kind; purgatives are sometimes called for; and the breast must be supported by a bandage or sling, having the milk drawn from it several times daily.

This inflammation may pass into suppuration, forming the condition present in the case before us. The symptoms indicative of this event are an increase of deep-seated pain of a throbbing nature, and discoloration of the surface; but the most decisive diagnostic symptom is the sense of fluctuation to the touch. This condition may be accompanied by flushes of heat over the body, followed by profuse perspiration. The indications for treatment are to open the abscess by a free and early incision, to evacuate the pus and prevent it from burrowing among the fat and dissecting the lobules of the gland from each other; by this means we save structure, time, and suffering. The pus, in such a case, is generally of a cream-like consistency, of a light yellow color, with perhaps a few flakes of lymph, but always contains milk, which is evident under the microscope. The amount of pus discharged varies from an ounce up to a quart, being generally from four to six ounces.

The mammary gland is sometimes enlarged and painful from over-distention with milk, but a due attention to the symptoms will effectually prevent any one from confounding such a condition with the one just described.

After opening the abscess with a curved bistoury, a slippery-elm poultice was directed to be applied and renewed three times daily, the inflamed part to be painted with equal parts of tinct. iodine and alcohol, some laxative medicine given, and the patient enjoined to keep at rest for a few days.

DOUBLE HYDROCELE WITH CONGENITAL HERNIA.

Henry Porter, æt. 6 weeks, exhibited a distended scrotum, the enlargement extending into the lower part

of the abdomen. This tumor was first noticed by the mother when the child was two weeks old.

This affection may be hydrocele, or hernia, or both; but whatever it is, it was, without question, congenital in its origin. A hydrocele of the vaginal tunic of the testicle may exist by itself, and, in rare cases, may co-exist with hernia. On examining the scrotum we find that it is much larger than it should be, and the testicle is at its lowest portion. The tumor is soft, translucent, and fluctuates, but at one part has a peculiar gaseous feel.

Hydrocele is an accumulation of a watery albuminous fluid, generally in the vaginal tunic of the testicle, but it may be encysted in the spermatic cord. It receives the name of single or double, according as it is limited to one side or exists on both. It forms a soft fluctuating tumor, which by transmitted light is seen to be translucent; it frequently occurs in children, but is also a disease of adult life. It may be simulated by a scrotal inguinal hernia, which however generally is a denser tumor, and is not translucent; it receives a distinct impulse when the patient coughs or cries, and, if reducible, returns into the belly with a gurgling noise on applying taxis. An exploring-needle, however, would settle a doubtful diagnosis, as its withdrawal would be followed by a drop of clear fluid if the tumor were hydrocele.

Congenital scrotal hernia will be readily understood by remembering the course which is followed by the testicle in its descent. This organ is originally developed, during intra-uterine life, in the upper and back part of the abdominal cavity, immediately under the kidney and behind the peritoneum, to which it is firmly attached. By the contraction of the fibres of the "gubernaculum testis," the testicle is gradually brought to the opening of the internal abdominal ring, through it, and along the inguinal canal, until, emerging from the external abdominal ring at about the seventh month of foetal existence, it assumes the position that it occupies in after-life. In its descent it draws with it the peritoneum, forming a funnel-shaped process extending through the inguinal canal to the testicle. Generally the sides of this peritoneal canal grow together shortly afterwards, and degenerate into a fibrous cord, thus obliterating the cavity; but nature sometimes fails to do this, and the communication remains open, and when the child cries the bowel is forced down, forming oblique inguinal hernia. This is called congenital hernia. Now, if hydrocele also exist, the fluid, by pressing on the tumor, might readily be made to recede into the peritoneal cavity through the abnormal opening. In the case before us, both conditions are evidently present. The watery, fluctuating part of the tumor is the fluid contents of a hydrocele, and the denser, gaseous portion is undoubtedly a loop of intestine.

A less careful diagnosis here might have destroyed the child's life; either from an incautious puncture of the bowel, or, by endeavoring to cure the hydrocele by adhesive inflammation, the morbid action might readily extend by direct continuity of structure and produce fatal peritonitis.

To promote absorption of this fluid, a weak solution of hydrochlorate of ammonia in water (grs. x to f $\frac{3}{4}$ j) will be used,—a cloth wet with this shall be kept constantly to the part. Treatment for the hernia must be deferred until the child is a little older. He is too young now to wear a truss, as his skin is too delicate and tender, and the pressure would irritate it. It would also be impossible to keep such an apparatus clean. For these reasons a truss should never be ordered for a child so young, as its use may be dispensed with for a few months, with advantage to the patient and comfort to his attendants.

A NEW edition (the third) of the "Philadelphia Medical Register and Directory," will soon be issued.

WILLS OPHTHALMIC HOSPITAL.

SERVICE OF H. E. GOODMAN, M.D.

Reported by CHARLES K. MILLS, M.D.

EXTRACTION OF CATARACT BY LIEBREICH'S NEW METHOD.

G. R., æt. 77, in his right eye presented a good example of an amber-colored, senile cataract. The left eye had several months previously been operated on successfully by Von Gräfe's modified linear extraction method.

On consultation, it was decided to extract, and after the patient had been in the hospital two days, the following operation was performed, the pupil having been strongly dilated with atropine. The patient was placed upon his back; no anæsthetic was administered. Dr. Goodman stood behind the head of the patient, and carefully elevated the upper eyelid with the index finger of his left hand, steadying the eyeball by gently pressing the middle finger against the inner canthus. In his right hand he held a small Gräfe knife, with its back horizontal and backwards, the plane of the blade making with the horizontal meridian of the eye an angle of about 45°. With this knife he punctured the sclerotic about one millimetre behind the corneal margin, and at a point two or three millimetres above a line drawn horizontally from the upper pupillary margin of the iris. The knife was then passed straight across through the anterior chamber, and brought out at a point corresponding to that of entrance, namely, in the sclerotic, but as close as possible to the sclero-corneal junction. Pushing the knife forward gently, and then retracting it, he finished the incision, after which the eyelid was allowed to drop carefully. Liebreich generally makes his incision below the pupil, although he states that it can be made either downwards or upwards, as in the case we are reporting, according as the surgeon operating may prefer.

The upper lid was again elevated carefully, a cystotome was introduced through the opening in the cornea, and the anterior capsule of the lens was lacerated.

Iridectomy was not performed.

The upper lip of the corneal wound was now depressed slightly by means of the index finger of the left hand, and gentle pressure was made upon the cornea beneath the wound by a tortoise-shell Daviel's spoon, when the lens placed itself in the opening, and by a little additional pressure above and below was entirely expelled. By gently rubbing and pressing upon the closed lips, some remaining cortical matter was removed. The pupillary margin of the iris having entered the wound, it was carefully pushed back by means of a curette, when the pupil became round. An eight-grain solution of sulphate of atropia was instilled, a bandage with a compress of lint was lightly applied, and the patient was put to bed.

At the time of making this report, ten days after the operation, the patient is still in the hospital, and is doing well. A strong solution of atropine has been instilled twice daily. He has no considerable pain or inflammation in the eye, the corneal wound is healing finely, and the cicatrix is not easily seen at a short distance. He has sufficient vision to promise eventually a good result in this respect.

Dr. R. J. Levis, one of the surgeons to the hospital, has operated by this method of Liebreich upon fourteen cases of cataract, with a good result in every case.

PROF. NÉLATON.—Private advices announce that the health of this distinguished surgeon is much improved, if, indeed, the accounts of his illness were not from the first considerably exaggerated. It is to be hoped that both statements are true.

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EDITORIAL.

OUR DEALINGS WITH THE INSANE.

IT would be idle to deny that great defects exist in the present system of management of the insane, or at least in its practical working in this country. The subject is one of such magnitude that anything like a discussion of it here would be out of the question; but we would urge certain points on which, in the light of recent developments, the necessity of reform seems most pressing.

And first, as to the profession at large. The curriculum of every medical school should include the study of the diagnosis, and to some extent of the treatment, of mental disease; not merely as a branch of medical jurisprudence, but as one of the qualifications for the ordinary practice of the profession. Every physician should have such a knowledge of insanity, of its physical and psychical symptoms, as to enable him to recognize it and its counterfeits; as to enable him to say intelligently what are the prospects from medical or moral treatment, and to judge whether removal to an asylum is or is not necessary.

Secondly, as to the process of placing the insane under restraint. Unless the legal forms are disregarded, it would seem that ample securities are provided to insure the admission of none but suitable cases into our hospitals. An unnecessary multiplying of difficulties would work evil, and perhaps very great evil, in the other direction. It may be, however, that the responsibility attaching to the giving of certificates in these cases is hardly enough realized; and the signatures appended to them should certainly be at least as carefully scrutinized and verified as those of a bank-check. We know of one instance in which a patient was taken into an insane hospital upon a certificate signed by two physicians in a neighboring State, endorsed by a physician in this city who did not know their signatures to be genuine, and whose handwriting, like theirs, was unknown to the physician of the institution.

In regard to the rectifying of mistakes and the release of those improperly confined in insane asylums, the actual fact seems to be, in the opinion of those best qualified to judge, that they are so rare that the existing provisions are ample. There would be continual appeals, attended with much needless trouble and expense, if the patients themselves were allowed to make application to the courts whenever they thought themselves wrongly detained.

Thirdly, as to our asylums. Most of these, in our humble opinion, are too large for the control, both administrative and professional, of any one person. They are in one sense too private; they are not under the inspection of any disinterested authority. On the other hand, in large institutions of the kind it is impossible to avoid much exposure of patients to sometimes ill-natured and gossiping observers.

Again, we cannot but think that far more important contributions to the general stock of knowledge on the subject of insanity ought to have been made by those in charge of our great and expensive hospitals. This, however, is in most cases rendered impossible by the pressure of daily duties.

Other topics suggest themselves, such as the proper disposal to be made of criminals shown to be insane, and the best way of providing for the care of the insane poor.

In all these matters the profession are deeply interested, and there are those among us who could speak knowingly upon them. We should be glad to receive communications bearing upon the solution of difficulties of such vital concern to human progress.

THE HOTTEST MONTH AND HOTTEST SUMMER ON RECORD.

IT can hardly be necessary to apologize for placing before our readers, in this prominent position, the following statistics, which speak for themselves:

	1871.	1872.
Mean Temperature of Eighth Month (August), per Pennsylvania Hospital . . .	78.49 degs.	81.64 degs.
Highest point attained, do. . .	92.50 "	97.00 "
Lowest point during do., do. . .	64.00 "	58.00 "
Rain during the month, do. . .	5.97 inch.	8.31 inch.
Deaths during the month, being for four current weeks for 1871 and five for 1872 . . .	1300	2146
Average of the mean temperature of Eighth month (August), for the past eighty-three years . . .	73.33 deg.	

Highest mean of temperature during that entire period, <i>this year</i>	81.64 degs.
Lowest mean of temperature during that entire period, 1816	66.00 "

SUMMER TEMPERATURES.

Mean temperature of the three Summer months of 1871	78.88 "
Mean temperature of the three Summer months of 1872	80.09 "
Average of the Summer temperatures for the past <i>eighty-three</i> years	73.67 "
Highest Summer mean occurring during that entire period, <i>this year</i>	80.09 "
Lowest Summer mean occurring during that entire period, 1816	66.00 "

In reference to the intense heat the above speaks for itself: "*The hottest month and the hottest summer on record.*" The nearest approach for the *month* occurred in 1863—79.50 degrees, and for the *summer* 1870—78.88 degrees. The month previous, it may be remembered, was also the hottest Seventh month ever known here, while the *Sixth* had only been exceeded *twice* during the long period of *eighty-three* years, viz., 1865, only a fraction of a degree, and 1870, about a degree and three-quarters.

While the Pennsylvania Hospital records 97 degrees as the highest point reached *there*, there were some localities in the city, very much exposed to the heat, where the mercury touched 102 degrees in the shade.

The rainfall for the past three months has been unusually large, the following table giving a statement of former years:

Summer of	June.	July.	August.	Total.
1872, . . .	4.22	11.22	8.32	23.76
1871, . . .	3.77	6.81	5.97	16.55
1870, . . .	2.86	3.95	5.12	11.93
1869, . . .	6.58	2.88	1.28	10.47
1868, . . .	4.37	3.51	2.65	10.53
1867, . . .	11.02	2.38	15.81	29.21
Mean, 35 years .	4.10	4.08	4.97	—

In comparing the *mortality* for the month of *this year* with *last*, it must be borne in mind that in 1872 records *five* weeks, and 1871 only four. While on this subject, it may be well to add that for the week ending 6th of Seventh month (July), *this year*, 764 deaths were recorded, while the nearest approach to it during the past twelve years, we find, by an examination of the article above referred to, to have taken place "in the week ending July 21, 1866, viz., 739."

We owe these observations to Mr. J. M. Ellis of this city.

PRAYER AS A REMEDY IN SICKNESS.

IT is stated in foreign medical journals that a proposition has been made to set apart certain wards in hospitals, the patients in which should simply be prayed for. We can hardly think that Prof. Tyn-dall, whose name is coupled with this suggestion,

could have really given his countenance to a scheme so totally opposed to all the principles of common sense. As well might a business man expect his affairs to prosper, or a farmer his crops to flourish, by praying for success, without the use of any ordinary means. The fable of the teamster whose wagon was stuck in the mud, and who, imploring the aid of Hercules, was told first to put his own shoulder to the wheel, is familiar to every school-boy.

These remarks are made in no spirit of irreverence or unbelief, but in the conviction that true religion asks for no miracles.

CORRESPONDENCE.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES.

DEAR SIR,—In your last issue Dr. Peugnet replies to what he is pleased to call my "attempted philippic" upon his paper on the veratroidal alkaloids. In the beginning of this philippic, I spoke of his paper as "exceedingly interesting," and I will now add to this, in many respects, able; but I still think he is wrong in some of his conclusions, and also claim that my treatment of his article was throughout entirely respectful and within the bounds of courteous criticism, except it was in the use of the words "curious blunder," for which I now desire to substitute "error." I acknowledge that I did read the chemical portion of his essay somewhat hastily, and, by missing a single sentence, did state too strongly what I still believe, that the chemical investigation was not carried far enough to settle a disputed question.

In regard to the "curious blunder," Dr. Peugnet has entirely failed to understand the point I raised. It was *not the truth of the fact* that section of the par vagum arrests the vomiting and purging of veratria-poisoning that was questioned by me; but it *was the deduction* which he attributed to me, namely, *that therefore it is through these nerves that the alkaloids act on the intestinal tract*, that I objected to.

All these are, however, side issues, as are several others raised by him, and must be passed by without further notice, as space and time are valuable. The main issue is in regard to the physiological action of viridia. It is but justice to state that I read this portion of his paper carefully before writing the criticism, and further study of it has confirmed me in the opinion that his experiments were not sufficiently elaborate to establish his points, and that his explanation of the asserted discrepancies in our results cannot be true.

I used a principle, veratroidia, and got a certain amount of sedation. I used another principle, viridia, and got a greater amount of sedation, grain for grain. It is simple nonsense, then, to assert that the sedative powers of the latter alkaloid depended upon a contaminating portion of the former, because the less is never more than the

greater, and if the grain of viridia owed its sedative influence to a quarter of a grain of veratroidia contaminating it, then that quarter of a grain of veratroidia was stronger than the whole grain of the pure veratroidia. If this is not clear, I cannot make it clearer, unless by an equation. Let x = sedative power of a grain of veratroidia. $\frac{1}{4}x$ = sedative power of $\frac{1}{4}$ grain of veratroidia; and if Dr. Peugnet's explanation be true, o represents the sedative power of $\frac{1}{4}$ grain of viridia. Then the equation will be $\frac{1}{4}x + o = x + \text{something}$. I would not reiterate this idea, had I not been misunderstood previously by Dr. Peugnet.

There is no use in trying to reconcile my results with his conclusions. One or the other of us did not observe his experiments closely.

Further, I assert that there is nothing at all obscure in my previous criticism in regard to the existence of paralysis in cases of poisoning by viridia.

It must be borne in mind that the experiments of Dr. Peugnet are very crude; that there was no attempt whatever at measuring the condition of reflex action; that there was no record kept of the immediate cause of death, or of the power manifested in the convulsions. Yet in Experiment XXI., he says, "a general tremor, followed by a *partial loss of power*, more marked in the anterior extremities," and in two out of the three fatal experiments, it was noted that before death had drawn near the convulsions had grown weaker, so that death was presumably not from the convulsions. With the positive results of my own much more elaborate experience too fresh in my mind, I certainly looked on these facts as indications of paralysis, and I yet believe that, in these experiments of Dr. Peugnet, paralysis was really present.

Dr. Peugnet certainly makes a vital mistake in supposing that the use of a cardiometer or some similar instrument is not necessary to the experimental study of the circulation. The mere number of cardiac pulsations is of very little moment; for every practitioner knows that an exhausted, depressed heart will often beat very frequently, especially when it is irritated by emotion, muscular action, convulsions, etc., all of which disturbing causes were present in a high degree in his experiments. I must then reaffirm my judgment that his physiological study of the action of viridia upon the circulation was not deep enough to be of any real value.

My paper on viridia was a maiden attempt at a physiological investigation, and was not as complete as it might have been, but the experiments were carefully elaborated and noted, as far as they went, and their results cannot be overthrown by experiments in which not a single one of the modern methods or appliances was used, *especially as my results are in strict accord with those of previous experimenters*. As far as I am concerned, this matter must end here. The facts are now plainly before the profession, and any further discussion would partake too much of the character of a personal controversy to suit my views.

H. C. WOOD, JR.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES.

DEAR SIR,—Can you enable me to get out of a difficulty? Here is the position in which I am. It reminds me a good deal of one I read of when studying Renwick's Natural Philosophy, some thirty years ago. It appears that Galileo announced that bodies having the same specific gravity would reach the ground in the same space of time, when allowed to fall from a given height. To prove this, he went, accompanied by a committee of philosophers, to the top of the leaning tower of Pisa, and two stones of the same material, differing in size, were allowed to fall to the ground. They came down exactly at the same time. The committee, however, decided that they did not, *because Aristotle said they would not*. A similar yielding to authority was hardly to be looked for at the present age of the world, and in this bold country; and yet I have met with it, and wish to present it to you.

When I began to treat patients myself, I naturally used the same means, and employed them in the same way, as I had seen practised with satisfactory results by my teachers. When, however, in certain venereal cases where I had seen Ricord, Nélaton, and others give the protiodide of mercury, and the symptoms disappear, I endeavored to give it myself, I found very often the patients could not take it. I soon learned, again, that this medicine when procured at the shops of certain apothecaries, where it was either better made or better kept, could be taken without trouble, and with all the good effect observed in France.

Now, again, there are certain syphilitic symptoms that are neither altogether secondary nor altogether tertiary, but are what Ricord calls symptoms of transition.* To cause these to disappear, I was always taught that it was necessary to give the iodide of potassium, while you were giving at the same time the iodide of mercury. I had seen Ricord do this any number of times, and any one can see for himself what his opinion is, at page 629 of the work just cited. He says there, "When transition symptoms exist, from secondaries to tertiaries, . . . treatment by the iodide of potassium alone is not sufficient, and mercurials must be added. Here again, except in certain indicated cases, it is the protiodide of mercury that I prefer." I have myself reported cases, under the care of Nélaton, where the protiodide of mercury, in half-grain doses, was given in the evening, and the iodide of potassium, in fifteen-grain doses, in the morning, for weeks and months.†

Now, in these cases of transition symptoms I have for years been perfectly satisfied with the result of this treatment, *when the medicines were procured at certain shops*: those where the protiodide of mercury was good.

Some days ago I was stopped in the street by a member of a firm of apothecaries in this city, who wished to say how much he was aggrieved at my having directed a patient to cease taking these medicines, which had

* See Ricord's edition of Hunter's Treatise on Syphilis, page 580.

† See Clinical Lectures on Surgery, by Nélaton, pp. 614, 618, etc.

been procured at his shop, and were causing serious symptoms, and to have the prescriptions compounded elsewhere. The blame, he said, for the occurrence of these symptoms, was to be attached to the prescriber, and not to the furnisher, of the drugs. For his own benefit I invited him to my office, where I could show him the authorities just referred to. Notwithstanding all this, and notwithstanding his meeting in the office a patient who was then submitting to this very treatment with the most marked benefit, and with no abdominal inconvenience whatever, he left me, declaring that it was impossible to use the medicines at the same time; he had so been taught at the School of Pharmacy, and of course it was so; and, moreover, that he should refuse to put up the prescriptions, were they to be offered at his counter.

Now, Mr. Editor, while exceedingly perplexed by not being able to have a favorite prescription put up at the counter of this particular shop, and having recourse to you for help in the matter, I must own to feeling great delight at meeting with such reverence for a teacher's instructions, and such self-sacrificing scrupulousness in protecting patients' from the mistakes of a physician. It is not the only instance I have myself met with of extraordinary care at this same shop. Some years since, having something to do with the appendix of formulæ attached to Druitt's System of Modern Surgery, I copied a prescription, thus:

R Bismuthi trisnitratis,
Pulveris acaciæ,
Sodæ bicarbonatis,
Singulorum, ʒj;
Pulveris zingiberis, gr. v.

Misce, fiat pulvis.

It was carried to this shop, and a boy employed there brought it back, saying that Mr. — said I had forgotten to put the quantities of bismuth, soda, and gum arabic, and they had no *singulorum* in the shop.

WALTER F. ATLEE.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY, SEPTEMBER 12, 1872.

THE PRESIDENT, DR. J. H. HUTCHINSON, in the chair.

DR. J. H. CATHCART exhibited a specimen of *cancer of the pylorus, duodenum, and pancreas*, adherent also to the upper periphery of the *right kidney*.

The specimen was removed from M. A. B., æt. 46, who died Sept. 7, 1872; she was a widow, and a native of Ireland.

She first suffered from metrorrhagia nearly ten years ago; this at times was quite profuse, and very little influenced by treatment, but ceased some four years since, and did not return until about two months ago, when she had a slight hemorrhage, which, however, required no treatment.

She had also complained at times, for several years, of an intense burning pain in her stomach and in her back, both between her shoulders and in the lumbar region; also of swelling of her hands and face. These symptoms all yielded to treatment, so that at times she was entirely free from pain; but her appetite was very variable, and generally her digestion was fair, though she vomited occasionally after eating. For a few weeks before her death, she could retain scarcely anything on her stomach, vomiting half a dozen times a day whatever nourishment she might take, together with a dark-brown "coffee-ground"-like fluid. She presented the so-called cancerous cachexia.

On post-mortem examination, made by Dr. Porter and Dr. Cathcart, the stomach was found filled with a dark-brown fluid resembling that which had been vomited during life. The mucous membrane was pale and anæmic, and at the pylorus was a large cancerous mass which nearly closed the orifice, and involved also parts of the duodenum and pancreas; the latter being somewhat enlarged. The spleen and liver appeared normal in size and appearance. The kidneys were normal in size, but fatty, and the surface of the right one was adherent to the cancerous mass.

The womb was hypertrophied, pale, fatty, and in the cavity was found a small pediculated polypus.

The specimen was referred to the Committee on Morbid Growths, who reported that the case was one of *simple scirrhus of the pylorus*. Also that the infarctus in the kidney proved to be a simple embolic patch, the centre of which had undergone softening.

DR. C. M. CHESTON exhibited, for Dr. Packard, a specimen of *abscess of the kidney*, from W. E., white, sailor, aged 39. Was admitted to the Episcopal Hospital on the morning of the 10th of August, 1872. Stated that he was knocked off one of the coal-wharves at Port Richmond on the night of the 9th, by a couple of seamen who wanted to rob him. He admitted, however, that he had been drinking, and did not remember whether any words had passed between them before he was struck, or not. Was brought to the hospital by two policemen, who found him lying under the wharf, not insensible, but utterly helpless. Upon examination, it was found that he had fracture of both wrists (Barton's), but he had (to all appearances) internal injuries of a much more serious nature. Complained of very great pain over the region of the bladder on the slightest pressure. Shortly after his admission he passed about one ounce of bloody urine voluntarily. After this his water was drawn off for him with the catheter, but in no instance did we succeed in getting more than two ounces. Ordered morph. sulph. gr. ʒ, by the mouth, in the afternoon; and, the pain being very great, the dose was repeated late in the evening. On the morning of the 11th he was more comfortable. Catheter was introduced, and we drew off about the same quantity as that passed at each introduction of the catheter on the preceding day. The pulse and temperature about normal. Flaxseed poultices ordered over the seat of pain. On the afternoon of the 11th he asked for a urinal, and passed about eight ounces of urine, tolerably clear; this he did again at seven in the evening. On the morning of the 12th he seemed quite comfortable, though the tenderness over the lower part of the abdomen still continued. The abdomen was considerably distended and tympanitic; pulse 120. He was ordered twenty-five leeches over the abdomen; verat. virid. gr. ʒj in mist. neutral. ʒss, every four hours. In the evening his pulse had risen to 135; he voided his urine voluntarily and without difficulty. August 13, he seemed quite comfortable, had less pain; his pulse 96; but at 6.30 P.M. he was not quite so well. From this date his pulse gradually rose in frequency until it reached 128. August 21, he was not so well, had more pain over abdomen and

over the region of the liver. He was also considerably jaundiced, and had some diarrhoea, with a pulse of 124. August 23, he was about the same, with a pulse of 120, diarrhoea continuing. He was cupped over the seat of the pain, and ol. terebinth. gtt. x was administered every three hours. On August 24 he seemed better; had not so much pain, and was quite cheerful. August 30, to all appearances, presented a well-marked case of typhoid fever; pulse 140. His condition was not materially changed until September 3, when he began to sink rapidly, and died September 4, at 6 A.M.

The post-mortem was made in the afternoon of the same day, when there was found general peritonitis; the peritoneum being very much thickened. The liver was very large and fatty, and weighed six pounds. The spleen was large, firmly attached to the peritoneum, and weighed two pounds. Both kidneys were enormously enlarged, left kidney particularly so, its weight being three pounds; that of right, one and one-half pounds. Both contained cysts which were filled with a purulent liquid. The intestines were healthy. The bladder was contracted, and its walls were very much thickened.

REVIEWS AND BOOK NOTICES.

PRACTICAL LESSONS IN THE NATURE AND TREATMENT OF THE AFFECTIONS PRODUCED BY THE CONTAGIOUS DISEASES; with an Account of the Primary Syphilitic Poison and of its Communicability. By JOHN MORGAN, A.M., M.D., Surgeon to Mercer's Hospital and to the Westmoreland Lock Hospital, etc. etc. Small 8vo, pp. 335. Philadelphia, J. B. Lippincott & Co. London, Baillière, Tindall & Cox, 1872.

From a perusal of the book before us, it is at once evident that Dr. Morgan has had unusual opportunities for the study of venereal disease, both in private and hospital practice; but the manner in which he has chosen to present this experience is most unsatisfactory to the reader. The volume lacks several essential elements, the most patent of which is the total absence of order and system in the arrangement of the matter presented, paragraphs and chapters being grouped with no attempt at classification. In many instances the statements are vague, and the exact meaning difficult of comprehension, while here and there through the work the same subject-matter is dealt with more than once.

Dr. Morgan professes himself a "unitist," believing that rarely, though occasionally, the soft sore may be followed by syphilitic manifestations. Decidedly the most interesting feature of the book, however, is the statement, followed by a series of experiments, that the product by inoculation of the vaginal discharge of a patient suffering from syphilitic infection, is a chancroid, or soft sore; and further, that this sore is propagated as a chancroid, and is again capable of propagation still as a soft sore or chancroid. Hence the possibility of acquiring constitutional syphilis from the vaginal discharge of a syphilitic woman, though no sore be present. Dr. Morgan is a firm believer in the proper use of mercury, and gives preference to the inunction treatment, accompanied with small doses of Zittmann's decoction. He also expresses himself in favor of syphilization. The volume is extensively illustrated with wood-cuts, some of which are emphatically poor and totally out of place in a work claiming to take a position in literature. Though the work contains much of interest and novelty, evidently the result of study and observation with a large clinical experience, yet we cannot help thinking that the author would have benefited the profession more had he taken time to arrange his material and bring out his points. That the book was written hastily is but too apparent.

THE TEN LAWS OF HEALTH; or, How Disease is Produced and can be Prevented. By J. R. BLACK, M.D. 8vo. Philadelphia, J. B. Lippincott & Co., 1872.

This work, as its title indicates sufficiently, is intended rather for the instruction of the public than for the reading of professional men. And we wish it, and the books like it, could be more widely disseminated and read. Not that we wholly agree with the writer in all his points,—for example, in his absolute condemnation of all use of tea, coffee, and tobacco,—but in the main we think his views are sound, and that the welfare of families would be promoted by the adoption of them.

The "Laws" relate to pure air, adequate and wholesome food and drink, adequate out-of-door exercise, adequate and unconstraining covering for the body, the exercise of the sexual function, place of habitation, pursuits, personal cleanliness, tranquillity of mind, and intermarriage of blood relations.

We cannot but note the excellent mechanical execution of this volume.

GLEANINGS FROM OUR EXCHANGES.

HYGROMA CYSTICUM COLLI CONGENITUM.—K. Koester (*Verhandlungen der Physic.-Medic. Ges. in Würzburg*, n. f., Bd. iii. S. 18.)

A well-formed child, born at full time, came into the world with a large tumor the size of an apple hanging from the inferior maxilla on the right side, and occupying the entire sub- and retro-maxillary region.

The tumor was covered with movable integument, and fluctuated upon palpation. The amount of transparent fluid contained in the tumor steadily increased for three months, extending from the inferior maxilla to the clavicle, and from the median line in front to the anterior edge of the trapezius muscle on the back. Since difficulty of breathing now set in, several of the sacs near the surface were opened, but only a very small amount of purely serous fluid was extracted.

The wound healed by first intention, but in six weeks phlegmonous erysipelas broke out in the cicatrix, and rapidly passed, in some parts of the growth, to suppuration, and in others to gangrene of the skin; death soon resulted from exhaustion in the fifth month after birth.

Respecting the other organs of the body, the post-mortem examination was of a purely negative character. The tumor, now as large as a child's head, had extended beyond the limits already described, had broken through the fascia superficialis colli, and completely surrounded the sterno-cleido-mastoid muscle, as well as the large vessels of the neck, which, however, were uninjured.

The deeper part of the tumor reached the base of the skull and the somewhat narrowed meatus auditorius externus, the inferior maxilla and the vertebral columns. The tumor possessed no proper capsule, but the component chambers were separated by a very delicate membrane from the neighboring tissues, into which they had inserted themselves like an infiltration.

Upon incision a large quantity of clear fluid escaped, which in the region of the purulent infiltration appeared slightly opaque and tinged with blood. The clear fluid contained a few lymph-corpuscles and a small quantity of epithelial debris, while the opaque fluid was rich in pus-corpuscles and fatty, broken-down epithelium. A section of the tumor revealed a series of spaces filled with fluid, and closely pressed together. These were varied in size from that of a millet-seed to that of a walnut, and assumed very diverse shapes from pressure. The same delicate membrane already alluded to formed the partition between the component parts of the morbid growths.

Injecting of Prussian blue into the collection of cysts revealed a system of delicate connecting canals between the component parts of the tumor. An examination of a portion of the tumor hardened in alcohol revealed an epithelial lining in the larger cavities, which showed all the features of pavement epithelium upon the application of a solution of nitrate of silver. The cells, which were invisible in the simple preparation without reagent, had the form and general appearance of the endothelium of lymphatic vessels, and only here and there, in the region of the purulent infiltrations, manifested the various stages of fatty degeneration.

In the centre of the tumor there were many spaces filled with coagulated blood, which in some places appeared to be fresh, while in others it manifested the various stages of retrograde metamorphosis. Since, therefore, amorphous as well as crystalline pigment was found in the tumor, and since extravasated blood was found in the trabecular septum dividing the cavities from each other, it is evident that the case was not one of ordinary angioma cavernosum, but of hemorrhage into the cysts composing it.

The peripheral cavities grew smaller, and the interstitial tissue separating them increased in thickness; at the same time the communicating canals became coarser and were found closer together. These topographical changes produced the appearance of irregular and varied anastomosis between ordinary lymphatics. Near the centre, these cavities contained fibrinous coagulations, but towards the periphery they were empty and collapsed.

The interstitial tissues which divided the cavities from each other were composed of connective tissue, rich in fibres and cells, and contained, here and there, peculiar round nodules; these were composed of a mass of lymphoid cells, supplied with from one to four nuclei, within a delicate and vascular reticulum, which became coarser towards the periphery, and united with the trabeculae which surrounded the larger spaces.

Koester regards these nodules as lymph-follicles, the coarse net-work at the periphery as lymph-sinuses, and the surrounding larger canals and cavities as distended lymphatic vessels.

In the region of the purulent infiltration, a large number of small round cells were found, as well as numerous large, stellate, anastomosing cells, with swollen and opaque contents.

These appearances were due to the distention of the initial lymphatics within the interstitial trabeculae, with fibrinous and granular fatty contents from the cysts, which had been forced from the adjacent cystic cavities as a result of an overflow of their contents. In attempting to force Prussian blue directly from the cutaneous surface into the cysts, the lymphatics of the skin as well as a number of the cysts became filled with the injected fluid.

Since, however, extravasation of the coloring-matter occurred, it must remain undecided whether the coloring of the contents of the cysts was accomplished by the direct way of the lymphatic vessels or not. Ponfick, in a criticism upon the case, in the *Centralblatt für die Medic. Wissenschaften*, 20th July, 1872, says the general communication of the cavities with each other, the direct passage of the wall of the cyst into the dilated canals, and the connection of the latter with the sinuses of undoubted lymphatic glands, the continuous epithelial lining of the inner surface, the purely lymphatic nature of the fluid contents, prove beyond doubt that the case is one of distended lymphatic vessels. The tumor must, therefore, be characterized as lymphangiectasia congenita.

AN ALLEGED DEATH IN NEW YORK FROM NITROUS OXIDE.—The *Lancet* thus comments on this unfortu-

nate affair, mention of which was in all the daily papers a few months since: "We have received from New York the particulars of a case in which death speedily followed the extraction of teeth after an ineffectual endeavor to administer nitrous oxide gas. A jury of ten persons, each of whom wrote M.D. after his name, returned an elaborate verdict, commencing with the finding that the deceased 'came to her death from asphyxia or apnoea, as evidenced by the symptoms manifested by the patient before death, and the conditions found at the post-mortem, the asphyxia having, in our opinion, been induced by the inhalation of gas administered.' This is followed by certain comments or riders concerning the mode of preparation of the gas used in the case, and concerning the qualifications of persons by whom gas is administered.

"Upon such a finding, it is very possible that the case may come to be recorded as one of death from nitrous oxide; and, as the facts will by no means bear such an interpretation, it seems worth while to call attention to them in detail.

"Upon the testimony, however, the facts seem to admit of only one interpretation. The nitrous oxide could have had no more to do with the fatal issue, either directly or indirectly, than if it had never been brought into the room. The patient manifestly fainted from terror, doing so as soon as her state of mental tension was relaxed by the operation being completed. Her syncope was just a result of the reaction of an overstrung nervous system; and, if Mr. Newbrough had only laid her flat on the floor, she would probably have recovered in five minutes, have paid him his fee, and have walked away from West Thirty-fourth Street as well as she entered it. It was the unwisely holding her upright that determined the fatal issue; and although one must sympathize with the queer medical jury to the extent of admitting that no anæsthetic agent should be intrusted to a man who treats syncope by the erect posture, yet still, when we consider the wide prevalence of his error, we must not be too hard on the dentist. We have lately heard of a case in which a poor woman fainted on an English race-course, and the strong arm of the law, in the person of a stalwart policeman, instantly erected her in a sitting position, with her back against a post. Fortunately, a medical man passed by in time to save her from death by laying her down again until she recovered; but the chances of her following Mrs. O'Shaughnessy were at one time fearfully great. Moreover, 'sitting up' is the most common cause of death after or during enfeebling illness. You hear from the nurse or the friends that the 'poor dear *would* sit up to take beef-tea,' or '*would* sit up on the nightstool,' and that he or she '*went off like a lamb.*' We once witnessed a very sad scene, in which a group of relatives were holding up the corpse of a fine girl, who probably would have been in no danger if she had been allowed to remain where a faint had caused her to fall. Strangely enough, she was to have undergone an operation on the following day; and her death, if it had been twenty-four hours delayed, might easily have been attributed to chloroform.

"In this last circumstance—the possible coincidence in point of time of the administration of an anæsthetic with sudden death from some other cause—we have a factor that must never be lost sight of in such cases. There is one well-authenticated history of a man who went to have a tooth drawn, and asked for chloroform. The operator had none, and went a short distance to fetch it, to find his patient dead on his return.

"The absence in Mrs. O'Shaughnessy's case of any apparent cause for sudden death other than emotional syncope and the upright posture, and the entire sufficiency of these to explain the occurrence, seem to render the verdict of the New York jury one of the most

astonishing on record. It can hardly fail to be challenged by American medical journals, and we shall be curious to see what attempts are made to justify it."

A RARE CASE OF VASCULAR ANOMALY (C. Aebv: *Corresp. Bl. für Schweiz. Aerzte*, Jahrg. II., No. 6).—At a post-mortem examination of an old man, the following curious distribution of vessels was found, the chief peculiarity of which consisted in the fact that the abdominal aorta gave off only two large branches instead of three. The coeliac artery and the superior mesenteric artery arose from a common trunk, which was given off at the aorta from the usual point of origin of the superior mesenteric artery. The common trunk of these important vessels was very small and thin in its central portion, but suddenly enlarged after sending off the hepatic artery and a branch which instantly subdivided into a series of small vessels to the spleen, the stomach, and the small intestines, in order to anastomose with the normal inferior mesenteric artery by means of a long arch, which followed accurately the flexura linealis and the pars descendens coli, as well as a part of the sigmoid flexure.

The immediate cause of this abnormal connecting branch between the two mesenteric arteries appeared to be an almost complete thrombosis in the narrow initial portion of the arterial trunk, produced by a calcareous and aneurismal dilatation of the aorta, which had rendered the arterial trunk almost impervious as far as the point of origin of the hepatic artery. In alluding to this case in the *Centralblatt für die Medic. Wissenschaften*, July 27, 1872, Ponfick says that a portion of this anomaly may be regarded as congenital, but that much is due to the later chronic changes in the vascular apparatus.

HYPERTROPHY OF THE TONGUE (G. Maas: *Arch. f. Klin. Chirurgie*, xiii., B. 3, H.).—In the surgical clinic in Breslau, during the past year, there were five cases of hypertrophy of the tongue reported. They were all congenital in their origin; the tongue was, in some instances, affected on one side only; in others, throughout its entire structure. In one case the hypertrophy of the left half of the tongue was accompanied by hyperplasia of the entire left half of the body. All the cases were treated by means of the galvano-caustic. The microscopical investigation in one case, two years old, revealed complete hyperplasia of all the tissues of the tongue, and, in three others, new growths of connective tissue and vessels, so that the tongue was completely metamorphosed into a spongy, cavernous mass.

The least amount of tissue-changes was in a patient three years old, a greater amount in one of twelve years, and the most prolific changes had occurred in a patient twenty-one years old.

Hence the conclusion that every case of macroglossa first consists of hyperplasia, to which is added increase in connective tissue and vessels, as a secondary result of continual irritation caused by the enlarged and protruding tongue.

ANCHYLOSIS OF THE INFERIOR MAXILLA CURED by the formation of a false joint on each side (G. Maas: *Arch. f. Klin. Chirurgie*, xiii., B. 3, H.).—A man, 27 years old, had had in his seventh year an attack of scarlatina, which left him with an inflammation of the maxillary articulation on both sides, which was followed by complete ankylosis. Both the inferior and superior maxillary bones had suffered in consequence an arrest of development. Middeldorpf excised on one side, and subsequently Fischer on the other, a wedge-shaped piece from the inferior maxilla, the base of the wedge being downwards, according to Esmarch. The mobility had remained perfect at the time of the report, four months after the operation.

SWALLOWING A FORK (*Berliner Klinischen Wochenschrift*, July 8, 1872).—In the proceedings of the German Chirurgical Society, Herr von Adelmann makes the following statement:

Very lately a man in Italy has excited great interest in the public mind, as well as among the members of the profession, by having swallowed a fork. Herr von Adelmann says that he has heard of five similar cases: three occurred in France; in two of these cases, gastrotomy was performed with success, and, in one case, the fork passed out with the faeces twenty months after it had been swallowed.

The speaker then proceeded to narrate a case which occurred in Russia.

A peasant in Wiatka, during an attack of delirium tremens, swallowed a fork with a wooden handle, the whole being five inches long. For six months after this act he suffered from pain in the stomach, loss of appetite, and repeated attacks of vomiting. At last he presented himself for treatment at the hospital, when an examination revealed, between the seventh and eighth ribs on the left side, a fluctuating spot with a fistulous opening, discharging an offensive pus, and through which a metallic body could be felt.

The fork was removed by Dr. Hohlbeck from the abscess which had thus formed on the left side. After the discharge of a few pieces of the seventh and eighth ribs, the abscess healed. The patient died three months later from other causes, and at the post-mortem examination the wound of the stomach was found to be perfectly adherent to the adjacent tissues, unaccompanied by any disease in the latter.

The fifth case alluded to by Herr von Adelmann was relieved temporarily by gastrotomy; and, in conclusion, he recommended in such cases generous diet, pushed to distention, in order to allow the fork to pass more readily through the pylorus, or to cause a more rapid adhesion between the stomach and the abdominal coverings, or to prevent entirely any injury of the stomach by the fork.

It is also evident, even from the slender experience given by these cases, that secondary gastrotomy is practicable.

MISCELLANY.

NEW PROFESSORSHIP.—A Professorship of Ophthalmic and Aural Surgery has been established in the Royal College of Surgeons, in Ireland, and Mr. Henry Wilson, Surgeon to St. Mark's Ophthalmic Hospital, and Examiner in Ophthalmic Surgery in the Dublin University, has been appointed to it. This, says the *Medical Times and Gazette*, is the first of the kind instituted in Ireland.

INDIAN MUNIFICENCE.—Under this heading the same journal announces the offer of a donation of £20,000 to the funds of the new Medical College at Allahabad, from the Maharajah of Vizianagram.

This "heathen" example is followed by Lord Cado-gan, according to the *South London Press*, in "supporting the Rate-payers' Association in Chelsea against the scheme of the Local Government Board in the erection of an infirmary for that locality, at a cost of £20,000."

SIR JAMES SHAW WILLES, Judge of the Court of Common Pleas of London, committed suicide October 3, while temporarily insane by reason of the extreme suffering consequent upon a severe attack of gout.

THE NAVAL MEDICAL BOARD for the examination of candidates for admission and promotion in the medical corps of the navy, which has been in session in this city since 1868, has been re-convened in Washington, with the following officers: Medical Director Charles D. Maxwell, President; Medical Director William Grier, Medical Inspector Thomas J. Turner, Surgeons Albert L. Gihon and Richard C. Dean, members; and Surgeon Joseph Hugg, Recorder.

THE *Lancet* of July 13 says, "At an inquest held last week on the body of a French lady who died from heart-disease, a New York physician, Dr. Petitjohn, who was called as a witness, stated that for twenty years he had been coroner in New York, and that in that city the jury was always composed of six persons, a number which was found to answer admirably. Dr. Lankester admitted the effectiveness of such a plan in ordinary cases, but thought that in serious and difficult cases it was advisable to summon a jury of twelve."

A CURIOUS but by no means unusual lawsuit was lately decided in France. A surgeon extracted a piece of cartilaginous meat from the trachea of a lady, and charged her £20 for the operation. The lady considered the amount excessive, and said that Nélaton himself would not have asked such a sum. Dr. Nélaton was then appealed to, and said that, taking into consideration the position of the lady, the charge was moderate. Ultimately a jury awarded the surgeon £12.

DR. JOHN K. MASON, a well-known retired physician of this city, died on the 1st of October.

THE NEW GERMAN HOSPITAL.—The board of directors of the German Hospital have taken formal possession of the new hospital building at Corinthian and Girard Avenues, and the patients now in the old building will be removed into the new in the course of a few days. It is supplied at present with seventy-two beds, and the capacity of the institution will be increased in the spring.

It is stated in the daily papers that on the 25th of August the wife of a physician, in the town of Canaan, N. Y., died from the effects of chloroform, administered to her by her husband for the purpose of extracting some teeth.

THE *Pull Mall Gazette* of August 15 says, "Strange scenes are to be witnessed in what Carlyle terms 'that monstrous tuberosity of civilized life, the capital of England.' That one family should collectively occupy one sleeping-room, is or ought to be a remarkable circumstance, but that ninety-two persons should sleep in three rooms is still more striking; yet it seems that such is actually the case at No 1 George Street, near Worship Street. On Tuesday a witness was called to prove an alibi in a case tried at the Middlesex Sessions,—a woman who keeps a lodging-house on the premises in question, comprising three rooms and a kitchen. In the course of her evidence it was elicited that, although no one slept in the kitchen, the three rooms were shared by ninety-two persons as sleeping-apartments, thirty sleep-

ing in one room. Economy of space can hardly be carried beyond this point, unless people are stuffed up the chimneys, or allowed to repose in the cisterns and water-butts. The lodging-house, it was stated, is 'licensed,' and of course, if the authorities approve, there is nothing further to be said in the matter."

M. REVILLOUT, in the *Gazette des Hôpitaux*, quotes (*British Med. Journal*, May 31, 1872) certain statistics published by the French Minister of Public Instruction, in regard to the medical profession. In 1866, there were in France 11,643 doctors of medicine, being 1000 more than in 1847; while the number of *officiers de santé* was 5697, the decrease, as compared with 1847, being 2145. There was thus a total decrease of 1145 medical practitioners, notwithstanding that the population had increased from thirty-four and a half millions to thirty-eight millions. M. Revillout attributes this falling off in a great measure to the defective encouragement afforded by the State to high-class education.

A DISHONEST MEDICAL OFFICER.—The *San Francisco Post* of the 14th of August states that Dr. F. H. Engles, who has been for several years apothecary and assistant-physician of the city and county hospital in that place, but who lately resigned at the request of the Board, has been accused of systematically thieving from the hospital supplies committed to his charge. Drugs worth over \$600 were offered by him to a New York house for \$429.75, and suspicion was excited, which led to inquiry, and the detection of the crime.

Such breaches of trust on the part of physicians are, we are glad to be able to say, extremely rare.

THE EX-EMPRESS CARLOTTA was some months since said to have become once more violently insane, and to be failing rapidly in physical health; a favorable change has, however, again taken place in her condition.

RAILWAY AIR-CUSHIONS.—A writer to the *Medical Times and Gazette* refers to the fatigue of the limbs produced after a long railway journey as due mainly to the trembling motion of the floor under the feet, and states that, having suffered considerably from this abuse, he was induced to try the experiment of using the well-known air-cushioned footstool. This answered so well that he has never travelled without using one in this way, and has found the effect to be a remarkable improvement.

MORTALITY OF PHILADELPHIA.—The deaths reported at the Health Office for the week ending October 5, 1872, were 240; of which 118 were of adults, and 122 of minors. Among the causes assigned were:

Consumption of the Lungs	36
Other Diseases of the Respiratory Organs	29
Diseases of the Circulation	12
Diseases of the Brain and Nervous System	33
Zymotic Diseases	20
Casualties	10
Dysentery	5
Cholera Infantum	3
Old Age	10
Stillborn	15